North Carolina Department of Health and Human Services

Gattex PA Request Form

Beneficiary Information

1. Beneficiary Last Name:_____2. First Name:_____

3. Beneficiary ID #:_____4. Beneficiary Date of Birth:_____5. Recipient Gender:_____

Prescriber Information

6. Prescribing Provider NPI#:_____

7. Requester Contact Information Name:_____Phone #:_____Ext:_____

Drug Information

8. Med requested: ___Gattex

9. Quantity per 30 days_____9a. Duration_____

For Coverage of Gattex

New Therapy

10. Is the beneficiary age 1 or older? Yes___No___

11. Does the beneficiary have a diagnosis of short bowel syndrome (SBS)? Yes___No____

12. Has the beneficiary been dependent on parenteral nutrition for at least 12 months? Yes___No_____

13. Is the beneficiary receiving parenteral nutrition at least 3 times per week? Yes___No____

Continued Therapy

14. Is the beneficiary continuing to receive parenteral nutrition while taking Gattex? Yes___No___

Signature of Prescriber:_____Date: _____

(Prescriber signature mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to NCTracks at: (855) 710-1969
Pharmacy PA Call Center: (866) 246-8505